CONSULTATION RESPONSE – MID-STAFFORDSHIRE NHS FOUNDATION TRUST

Jeremy Lefroy MP (own submission and on behalf of the Stafford Hospital Working Group)

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1.0 Introduction

This response is of necessity detailed and goes well beyond the questions asked by the Administrators in their consultation because the matters in question are of such importance to my constituents.

It builds on the work which has been done over the past year by the Working Group which I chair and will therefore include much that has already been submitted to the Administrators.

It also extends beyond the situation of the Mid-Staffordshire NHS Foundation Trust (MSFT). It is clear that the problems which MSFT faces – principally its relatively small size – are not unique and that the solution for MSFT is likely to be considered to be a solution for many other smaller Trusts and therefore acute District General Hospitals in England.

There is therefore a great responsibility on all those involved with the Administration of MSFT to make the right long-term decisions not only for the people served by MSFT but also for the people served by the NHS in England.

2.0 Emergency and Urgent Care

"Stafford Hospital should continue to have a consultant-led Accident and Emergency (A&E) department between the hours of 8am and 10pm daily."

(Recommendation 1)

I support this recommendation with the following provisos:

1) ***That the operation of Stafford's A&E be reviewed on a regular basis by the Trust board (I suggest every 6 months) with the aim of returning to 24/7 operation;***
2) ***That, in the meantime, a primary-care out-of-hours service be co-located at Stafford Hospital to cover at least the period 10pm-8am for non-ambulance cases (if not 24/7). (see Alternative Proposal for further details).***

2.1 Basis of consultation

Stafford Hospital actually has a 24/7 A&E department which was temporarily reduced to 14/7 from 1 December 2011 because of serious concerns about the care it could provide given the shortage of consultant grade doctors and senior nurses.

Major efforts were made during 2012 to recruit sufficient staff to return the department to 24/7 operation. However the commissioners and board decided in September 2012 that the department could not safely be returned to 24/7 operation.

As I understand it, any change to the operation of an A&E department must be subject to a public consultation and hence this consultation question should be: “Stafford Hospital should now have a consultant-led Accident and Emergency department between the hours of 8am and 10pm daily instead of the suspended 24 hour service.”

2.2 Hours of operation

The reasons given for operating the A&E department 14/7 instead of 24/7 are

- that an additional 4 consultant grade A&E doctors would have to be introduced across the network for a 24/7 service in Stafford to be clinically viable (378);
- Stafford has one of the smallest A&E’s in the country (132/150) based on attendances. On average 16 patients are attended by West Midlands Ambulance Service between 10pm and 8am who would be taken to Stafford if it were open.

I understand the reasons for the current operation 14/7. However I argue that these hours of operation should continue to be kept under careful consideration with a view to returning to 24/7 if demand increases.

The reasons for this are:

- Taking patients to other A&E units from the Stafford Hospital catchment area results in extra costs for WMAS as well as eventually requiring additional capacity at those other units. There may well be a point at which the cost of returning Stafford to 24/7 operation will be more efficient and provide better care for patients than providing further increases in capacity in other A&Es and the WMAS.
- A&E operates effectively until the last patient arriving by 10pm is seen and discharged/admitted. This can be as late as 2-4am. Hence the additional staffing required to resume 24/7 operation is less than required by a full additional 10/7 rota.
- Patients from the Stafford catchment area who are taken to other hospitals, and are admitted, often have to be repatriated to Stafford Hospital for step-down care, another additional pressure on WMAS.
- Patients who are taken by ambulance to other hospitals and are then discharged in the middle of the night have to find their own way back home by public transport if they do not have someone to collect them. This can result in substantial taxi fares.
- Patients who are admitted to other hospitals are, it appears, not always being discharged as early as other patients who are from the area local to that hospital. (There is some evidence that being visited frequently by loved ones speeds recovery).

- There is some evidence that patients are already waiting until 8am in order to attend Stafford A&E rather than travel. This puts additional pressure on the department at 8am and may result in patients waiting longer than is wise before attending A&E.

There is also the question of how many patients who require emergency or urgent treatment between 10pm and 8am and would normally attend Stafford take themselves to other hospitals. This is not shown by the WMAS figures.

The effect of reducing the hours from 24 to 14 per day is most felt by vulnerable groups, in particular the frail elderly, the disabled and single parents who were admitted (or whose family and loved ones were admitted to another hospital.

They are the people who would find it most difficult to maintain contact. Frequent visits are recognised as aiding recovery.

2.3 Recruitment and Retention

The TSA believes that the recruitment and retention problems for A&E at Stafford can be tackled by rotating senior doctors and nurses between hospitals in agreement with a neighbouring hospital (likely to be UHNS).

This makes sense.

A similar solution could also be used in other areas such as Paediatrics and Obstetrics and Gynaecology (see below).

2.4 A&E Attendances

I do not follow the reasoning behind the figures given for the percentage of patients who currently access A&E at Stafford who will do so in the future if non-elective/emergency general surgery and trauma surgery is no longer provided at Stafford. It is stated as 70%. This implies an average of 84 attendances per day compared with the current 120 (378). However elsewhere in the report (441), it is stated that there are an average of 4 cases per day (2 emergency surgery and 2 trauma). If it is only these cases which will no longer come to A&E in Stafford, the average number of attendance would be reduced to 116 and not 84. It is not at all clear how the figure of 84/70% is reached.

Either the figure is incorrect or there will be other categories of patients who currently come to A&E at Stafford who will not do so in the future.

If the average number of attendance is indeed 116 (ie 120 less 4 emergency surgery/trauma), then the statement that “The TSAs do not propose any changes to how the vast majority of local patients currently use the consultant-led A&E department at Stafford Hospital” (p24 consultation booklet) is correct.

However. if the average number is 70% of the current average (ie 84 instead of 120), the statement is not accurate as 70% cannot accurately be termed “the vast majority”.

3.0 Inpatient Services for adults

“An inpatient service for adults with medical problems will continue to be provided at Stafford Hospital for those who need to be in hospital.”

(Recommendation 2)

3.1 Inpatient service and MAU

I fully support the recommendation that the inpatient service for adults with medical problems be continued at Stafford Hospital for those who need to be in hospital. I welcome the fact that the TSA has listened to the argument that the forecast demographic changes in the local population are expected to lead to a greater demand for acute medicine and care for the elderly. This is an improvement on the CPT proposals.

The enhancement to the Medical Assessment Unit (MAU) is welcome as is the specialist support for the frail and elderly.

There is a proposal for a managed reduction in the number of acute medical beds which will be achieved by integration of care, the enhancement of MAU and demand management schemes.

3.2 Acute medical beds

While improvements to the way in which patients are cared for within hospital is vital and welcome, there must be no reduction in acute medical beds unless it can be shown that these measures actually do result in a need for fewer acute beds over a sustained period of time. This must take into account the fact that 85% bed occupancy is generally considered as high as the average should go commensurate with quality care.

It is also not clear from the recommendations whether all acute medical care currently provided at Stafford would remain. This needs to be set out.

3.3 Critical Care Unit

The proposal regarding the Critical Care Unit (CCU) is considered below. However a CCU level 3 is vital as part of the support services for acute medical inpatient services to ensure patient safety.

Travelling further to a full-time level 3 CCU (in case of a deterioration and multi-organ failure) would be difficult and potentially dangerous for the elderly who would constitute the highest proportion of these patients.

4.0 14/7 Frail Elderly Assessment Service

“As well as retaining the present inpatient service, a 14/7 Frail Elderly Assessment service is created to provide a one-stop assessment for older people and to take referrals from a wide range of sources.”

(Recommendation 3)

This is a very important recommendation which I strongly support. However it is not clear why it is described as 14/7 when it is clear that it will be run 24/7 and staffed by senior specialist nurses at night. Would it not make sense for the service to admit 24/7 so that frail elderly people from Stafford and the surrounding areas can be admitted at any time? It is precisely these patients who need to be as close to home and support as possible.

5.0 Rehabilitation / ‘step down’ beds

“Beds should be available at Stafford Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.”

(Recommendation 4)

This is also an important recommendation which I strongly support. Those who have to be treated at a specialist hospital need to have the opportunity to recover as close to home, their loved ones and support as possible. Recommendations 3 and 4 in particular give Stafford the opportunity to be known for providing the best possible care for elderly and vulnerable patients.

This recommendation could form part of a proposal to make Stafford and Cannock Hospitals hubs for integrated health and social care (see 19.0 below).

6.0 Maternity Services

“No babies should be born at Stafford Hospital’s consultant-led delivery unit as soon as other local hospitals have the capacity to deliver a service for more pregnant women.”

(Recommendation 5)

I strongly oppose the recommendation to remove consultant-led delivery from Stafford.

6.1 Numbers of births

The figure quoted by the TSA of approximately 1,800 births per year at Stafford does not accord with the figures which I have been given which are:

2007 2,437

2008 2,468

2009 2,231

2010 2,010

2011 1,870

2012 2,003

(Source: Midwifery service via Stafford Borough Council).

From these figures, the number of births has only fallen below 2000 in one year (2011). It is rising again after the decline which was substantially due to the well-known problems of Stafford.

There appears to be no reason why – with a rising birth-rate and increasing local population - the number could not again within the next 3-5 years reach the c2,500 births per year which is recommended as a minimum for a consultant-led unit.

Local people have expressed to me in person and through correspondence their passionate desire to retain childbirth at Stafford. They have given a number of reasons:

- The unit has a very good quality record and a high level of satisfaction from parents.
- The nearest alternative units are 45-60 minutes away on busy traffic routes. In childbirth, time is of the essence.
- Women wish to have the option of giving birth in a smaller centre closer to home and not be required to go to a much larger unit.

More generally, the move to concentrating childbirth in larger and larger units seems to be contrary to the Government policy set out in 2007 and reaffirmed in 2013 of providing choice to women over where they have their babies.

This was put into effect by the Government Policy “Giving Children a Healthy Start in Life” published on 25th March 2013.

Helping families to have the best start in life

We want women to have a positive experience of maternity care and to provide the best possible services for women and their babies.

We are improving maternity care by:

- ***giving women a single, named midwife who will oversee their care during pregnancy and after they have had their baby***
- ***making sure that every woman has one-to-one midwife care during labour and birth***
- ***giving people expecting a baby a choice about where and how they give birth***

If at least 1,000 births are transferred to UHNS from Stafford, the number of births at UHNS will reach more than 7,000 per year, making it one of the largest centres in the UK – and far larger than any unit in France or Germany.

The Royal College of Midwives says that the largest units delivering c 8,000 babies a year lose economies of scale because they require two teams of obstetricians.

Senior politicians, including the Prime Minister, have also expressed their wish to see a 'personal, local offering for expectant mothers' and not increasingly large units.

6.2 Quality

Stafford is recognised as being a good and safe hospital in which to give birth.

The elective Caesarean section rate is 1.7% against a national mean of 2.8%. The percentage of induced labours resulting in an emergency CS is 16.4% compared with the national mean of 30.2%. Spontaneous labours resulting in emergency CS are 5.5% as against 11.6%.

(Statistics are for 2011/12).

6.3 Access

Travel times to the alternative providers proposed would be longer and depend on roads which are frequently congested. Time is of the essence for safe childbirth.

(See also 15.0)

6.4 Alternative models (eg Midwife-Led Unit)

I advocate retention of a consultant-led unit for the reasons given above. The possibility of a midwife-led unit has been dismissed by the TSA on the grounds that few women are likely to opt for one even if it is local.

7.0 Inpatient Paediatrics and the Paediatric Assessment Unit

Children should no longer be admitted as inpatients to Stafford Hospital.

(Recommendation 6).

Children will be assessed at Stafford's Paediatric Assessment Unit the hours of which will be reduced from 24/7 to 14/7

(Recommendation 7).

I strongly oppose these recommendations.

7.1 Consultant levels

The main reason given for them is that there are currently too few consultants at Stafford Hospital to meet the clinical safety guidelines from the Royal College of Paediatricians and Child Health.

Yet the Clinical Advisory Group stated in its letter to the TSAs “The CAG felt that services would be further from rather than closer to College clinical guidelines and standards with these two models (LSS and CPT), ***albeit recognising that such standards are mainly aspirational rather than absolute.” (my emphasis).***

There are many other hospitals in England with inpatient childrens' services which do not meet these guidelines. The logical outcome of this recommendation is therefore that all those other services should also close as they are inherently unsafe. Yet this is not being proposed by the NHS or the RCPCH.

It appears to me therefore that the TSAs are placing a greater weight on these guidelines than they may be meant to bear.

I also understand that paediatric services current make a net contribution to the MSFT overheads and that therefore that is no question of their financial sustainability.

Currently Stafford is ranked 116th out of 167 hospitals for numbers of paediatric spells of more than one day and hence is by no means one of the smallest in the country.

It is well-known that there have been a number of reviews of children's services over the past 20 years. The place to consider what to do about children's services is as part of a proper regional review and not in the course of a Trust Special Administration which is on a short timescale and includes reviews of many other services.

7.2 14/7 senior nurse-led as against 24/7 consultant-led PAU

The Administrators’ report assumes that the PAU is currently operating 14/7 and therefore that their proposal involves no change. This is not the case. The PAU currently operates 24/7 at receives children at all times of day or night, as the correction to the Administrators’ report recognises. There is therefore a strong

question mark over whether the Administrators fully understood the nature and scope of the service provided by the PAU and its importance both to local residents and the local health economy.

Currently the PAU operates effectively 24/7 alongside a 14/7 A&E and there has been no suggestion that this causes difficulties. Indeed, one of the purposes of a PAU is to enable children to be seen directly on referral from GPs without passing through A&E. Removing the PAU service at night-time would both place additional pressure on other regional paediatric services and remove the availability of a local unit for parents whose children become sick overnight.

I am also concerned that the PAU will be nurse led with no on-site paediatricians. Although senior nurses will consult paediatricians at UHNS, this is no substitute for direct contact, especially in the case of children.

It is important to note that in Vol. 1 p88 Table 34 the NCAG is reported as stating that “Nursing recruitment to a standalone PAU without inpatient Paediatrics may be difficult”.

7.3 In-patient stays for children

Children, I am advised, tend to become sick quickly and often recover quickly. What is therefore vital for the people served by Stafford Hospital is a Paediatric Admissions Unit which is open - as now- 24 hours per day with the ability either to refer very sick children to a specialist hospital or to treat as in-patients those who are likely to recover within a relatively short period of time.

7.4 Accessibility and travel

It is particularly important that a PAU with in-patient capacity is offered at Stafford as otherwise they and their parents will have to travel 15-20 miles, depending on where they live, even for illnesses which are of short duration and do not require specialist treatment. In section 15.0 below, I consider on the difficulties which my constituents face in travelling to the hospitals will take over the paediatric services which it is proposed that Stafford will no longer provide.

7.5 Paediatric back-up for A&E

It is also important to maintain consultant paediatric presence at Stafford as a specialist backup to the consultant emergency physicians on A&E when they need a specialist opinion for a child presenting at the A&E department.

8.0 Emergency Surgery / Surgical Admissions Unit

Major emergency surgery should no longer be carried out at Stafford Hospital with the exception of minor surgical procedures which can be dealt with by

A&E or where the patient can be stabilised by A&E and scheduled to turn to Stafford Hospital for minor surgery.

Recommendation 8.

8.1 Numbers of procedures

In my response under Emergency and Urgent Care (above), I have already pointed out the discrepancy between the number of major emergency surgery cases which will no longer be carried out at Stafford (4 per day) and the fall of 30pc in expected attendances at Stafford A&E.

As I have already stated, this does not seem to accord with comment that "the TSA do not propose any changes to how the vast majority of local patients currently use the consultant-led A&E Department at Stafford Hospital."

I understand the argument that the number of unplanned procedures performed in Stafford each day (four) is small and that this is too low for it to continue because the theatre team will not be able to keep their skills up to date.

However I believe that this figure is disputed. It is vital that we know precisely how many patients would no longer be operated on at Stafford.

In a response to me, the TSA team mentioned that perhaps two out of the current four unplanned procedures currently carried out by the emergency team could in fact be carried out on elective lists which were in progress at the time. I would ask the TSA to address this in their reply.

8.2 Definition of ‘major emergency surgery’

It is also important that we understand what the precise definition of 'major emergency surgery' is. The TSA report mentions, for instance, the removal of an appendix or bowel obstruction. However the chart at the end of booklet mentions that bowel surgery will continue to be conducted at Stafford.

8.3 Complication of triage

Given the difficulty for paramedics to assess whether or not a patient falls within the definition of requiring major emergency surgery, ambulances are likely (and understandably) to take the cautious approach and go straight to a major acute hospital such as UHNS and RWH even when the patient may well have been able to be treated at Stafford.

This would result in a reduced caseload at Stafford and possible pressure for further losses of service. It would also unnecessarily increase the demand at UHNS/RWH.

8.4 Surgical Admissions Unit

I strongly oppose the proposed closure of the Surgical Admissions Unit (SAU). The introduction of the SAU at Stafford some years ago was considered to lead to substantial improvements in the way in which patients were treated at Stafford.

I understand that only about 10% of the current patients on the SAU relate to major emergency surgery. The remainder are a mixture of patients who have been admitted through A&E and have potential surgical problems, patients who have been admitted for elective surgery and other cases.

Removing the SAU would therefore have a great impact on several other services and indeed on the efficiency and quality of those services.

9.0 Critical Care Unit (CCU)

A small critical care area should be retained at Stafford Hospital, so that very ill patients who come to A&E or inpatients who become very unwell can be kept stable prior to urgent transfer to a larger specialist hospital.

Recommendation 9

9.1 CCU as part of the regional and national critical care infrastructure.

Critical care Units are a vital part of the region's and country's critical infrastructure. They cannot be viewed simply in the light of local need. The transport corridor serving Stoke, Stafford, Walsall and Wolverhampton has one of the busiest motorway networks in Europe (M6) and the busiest mainline railway (West Coast Mainline). UHNS Stoke is a major trauma centre and is required to serve a population in excess of 3 million in this capacity which involves use of its critical care beds. Stafford's location is ideal for hosting a smaller full level 3 critical care unit both to serve local needs and as a back-up for the larger units at Stoke, Wolverhampton and Walsall.

9.2 Current status of Stafford's CCU

Stafford's CCU is valued for its quality. In discussions with a senior surgeon at UHNS Stoke, I was told that the Stafford unit has an excellent reputation and skills which are complimentary to those in the larger unit at UHNS. The level 3 CCU at Stafford also provides a valuable training ground for doctors, nurses and other staff in the running of a smaller CCU.

The CCU has been part of ICNARC for 16 years and has consistently had good governance reports. It is a valuable part of the West Midlands Critical Care Network. There is a dedicated fully staffed team of nurses led by a nurse consultant, 24/7 staffing complete with a separate 7 consultant rota. The CC consultants work a seven day pattern and have been separate from general anaesthetists for about 8 years. The team is integrated and provides Critical Care outreach on the wards and emergency departments 24/7.

The CCU is in surplus and its costs are considered to be in line with other units.

9.3 Role of CCU in Stafford and consequences of TSA proposals

The CCU provides immediate specialist care and treatment to acutely ill patients and transition to higher levels of care and life support where necessary.

It is a vital service for the A&E Department and Acute Medical Admissions, both of which the TSAs propose to retain.

It also provides important backup support to

- general surgery
- endoscopy
- haematology
- chemotherapy
- gynaecology
- orthopaedics
- paediatrics
- other specialist surgical departments

Without this backup on site, there are new risks to patients at Stafford and hence safety is reduced. Standards for these services all point to the availability of level 3 Critical Care.

Without Critical Care consultants, there are three areas of great concern:

i) Acutely ill patients.

ii) Acute Critical Care period

iii) Transfer of patients

9.4 Increasing bed occupancy rates in CCUs

Concentrating level 3 CCU on fewer sites puts the health system at greater risk if, for instance, one site is temporarily closed by a serious infection or civil emergency.

Recent figures show that bed occupancy rates in CCU's across England are rising. I have compared the rates for February and June for each of the past three years.

Feb 11 82.5% Feb 12 85.4% Feb 13 87.8%

June 11 80.9% June 12 81.7% Jun 13 83.0%

(Source Govt Stat Service 26/7/13)

This gives an indication of a gradual increase in pressure on CCUs.

I therefore make the alternative proposal that a level 3 critical care unit at Stafford be maintained (as per Appendix 3) with the adjustments proposed

The regional health economy would therefore maintain its current capacity for level 3 critical care in terms of numbers of sites. This is very important for retaining capacity, flexibility and resilience in critical care in the region.

10.0 Elective and Day Cases

Elective care and day cases should remain in Stafford. This would include orthopaedic surgery.

Recommendation 10

I strongly support this recommendation. It is likely that the number of elective and day cases will increase due to demographics. It is important that this treatment is provided as close to home as possible, commensurate with the specialist service being available.

11.0 Beds for recovering patients at Cannock Chase Hospital

Beds should be available at Cannock Chase hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.

Recommendation 11

I strongly support this recommendation.

12.0 Elective Surgery at Cannock Chase Hospital

Elective surgery is retained at Cannock Chase Hospital. There should be new surgical specialities introduced.

Recommendation 12.

I strongly support this recommendation.

Given the bias in the tariff system towards elective surgery and the fact that elective surgery often therefore subsidies emergency and acute care, it is very important that a sharp increase in the amount of elective surgery in one place does not diminish it elsewhere and put at risk the financial viability of emergency and acute services.

13.0 Day Case procedures at Cannock Chase Hospital

The current range of day case procedures (surgical and medical), including rheumatology services, should continue at Cannock Chase Hospital and the range be increased where possible.

Recommendation 13

I strongly support this recommendation with the same comment as under Recommendation 12.

14.0 Dissolution of the Mid-Staffordshire NHS Foundation Trust

To allow for the TSAs' draft recommendations to work in a way that does not negatively impact the safety at other hospitals or their financial position, it is recommended that MSFT as organisation be dissolved.

Recommendation 14

14.1 Board representation

I strongly support this recommendation. It is very important that this is done in a way which ensures that those who depend on Stafford Hospital and Cannock Chase Hospitals are properly represented at board level in the new trusts of which they will be a part.

14.2 Services to be provided by the new trusts

It is also vital that the new Trust is directed to provide the services which are needed at Cannock Chase Hospital and Stafford Hospital - which, as stated elsewhere need to include consultant-led obstetrics/gynaecology, 24/7 paediatrics with children able to stay in, a full critical care unit and surgical admissions unit.

This will also provide the opportunity to make savings from the merger of administrative (rather than clinical) functions.

15.0 Alternative Proposal based on TSA’s premise of the dissolution of MSFT

15.1 Agreement that the Mid Staffordshire Foundation Trust (MSFT) should be dissolved.

My alternative proposal fully accepts the TSA's basic premise(14.0) that MSFT should be dissolved and Stafford and Cannock Hospitals be merged with other NHS Trusts.

This is a very important proposal and should not be lightly disregarded in the understandable and necessary concentration on which services are provided and where.

It will be the first time that a Foundation Trust has been dissolved and will mark a very significant change in the structure of the NHS. It is almost certainly likely to lead to much more networking between specialist acute hospitals and acute DGHs. In my opinion, this can only be to the benefit of patient care and safety and I welcome it.

The dissolution of MSFT should also mark a clear statement of intent by Monitor that it will not accept any further 'fudged' applications for Foundation Trust status. Better that Trusts take a good time to prepare themselves and ensure that they will be financially sustainable for 10-20 years ahead than that they should rush to gain a status which has proved such a problem for MSFT.

15.2 Alternative proposal

15.2.1 My proposal is that Stafford should immediately merge with UHNS and Cannock by Walsall/Wolverhampton in shadow form, at the latest by 1st January 2014 with adequate representation at board level for Stafford/Cannock. New Trust arrangements can be formulated in due course.

15.2.2 All services would be delivered on the current sites as now but work could immediately begin to achieve the cost savings from reducing executive management and back office functions from the former MSFT and bringing former MSFT costs more into line with the NHS average.

15.2.3 Work would also immediately start on networking clinical services across sites. Where there was a clear clinical and patient safety case for a transfer of a specialist service between sites, it would be made and consulted on. This has already happened on several occasions such as with the transfer of acute stroke and major heart attack services some 5 years ago and more recently vascular and urological surgery.

15.2.4 Services such as consultant-led paediatrics and obstetrics where provision as close as possible is especially important for patients and their loved ones, clearly desired by the local community and contributes to reducing health inequalities should be retained at Stafford for the whole transitional period of 4-5 years.

This would also have the advantage of allowing use of these services to rise to their normal long-term level, which has been adversely affected by the problems arising from the poor quality of care set out in the HCC and Francis reports.

15.2.5 As has been pointed out elsewhere in this response, retaining a full critical care unit at level three is vital as support both to these services and those which the TSAs propose to retain (especially A&E and acute medicine). There is room for cost saving in the plan out forward by the CCU department and described in this response.

There should also be the opportunity for additional funding through the regional critical care network. Keeping Stafford as a CCU3 site is important in maintaining the robustness of the region's and nation's critical care infrastructure.

15.2.6 The proposals for transferring major emergency surgery from Stafford should be considered much more carefully before a final decision is taken for their impact on other services both in Stafford and the trusts to which it would be transferred.

15.2.7 The trusts with which Stafford and Cannock would be merged would – backed by the CCGs and supported by transitional funding from the Department of Health – give guarantees that consultant-led obstetrics and paediatrics as well as level three critical care would continue to be provided at Stafford through the transition period with the aim of assessing their sustainability in the long-term.

15.2.8 The proposal to collocate a GP-led urgent care centre alongside A&E either at night-time or 24/7 should be considered again. There was much support for this from local clinicians before the CPT process started.

15.2.9 Very importantly, the opportunity should be taken to integrate acute and community services across the whole region. The hospitals at Stoke, Stafford, Wolverhampton, Walsall and Cannock can be used as key hubs for integrated community care rather than as 'boxes' into which patients are sent from and return to the community. This will undoubtedly help to ease the increasing demographic pressure on acute services in the coming years. The commissioners and the trusts can work with NHS England to develop an example of best practice in the region for the entire NHS.

15.2.10 The proposals for Cannock are welcome as they increase services at Cannock.

15.3 Similarities and differences with the TSA proposals

In conclusion, my proposal would be almost identical to that of the TSA's in four of its most important respects.

a) It would see the dissolution of MSFT, which is not sustainable as an organisation, but ensure that services could continue to be provided at Stafford and Cannock.

b) It would help to improve recruitment and retention of staff at all sites (Stafford, Cannock, Stoke and Wolverhampton/Walsall) by providing a greater range of opportunities and experience within single organisations.

c) It would help to improve the quality of services by much greater networking, allowing staff to learn from each other rather than remaining relatively isolated in smaller units.

d) It would provide a 4-5 year transition period which would be supported by revenue funding through the NHS/Department of Health to allow the trusts and services to bed down.

Part of this support should be to enable UHNS and where necessary the other trust(s) into which Stafford and Cannock would be merged to address legacy problems which they have, such as the £50m pa cost of the UHNS PFI.

Where my proposal differs from the TSA's is in that

a) It does not see the need to remove consultant-led maternity, paediatric services and a full CCU3. Rather it considers these essential properly to provide good quality services to the population currently served by MSFT.

b) It proposes a greater emphasis on developing integration of acute and community services, fully in line with Government, NHS England and local CCG policy.

16.0 Finances

This analysis is predicated on the following:

a) The figures are taken from the TSA proposals;
b) The period being examined is 4-5 full financial years from 1 April 2014 to 31 March 2018/9;
c) Stafford retains its current maternity, paediatric services and CCU3 with some specialist emergency surgery transferring to UHNS if it deemed necessary and clinically safe.
d) The estimated additional capital costs for all sites are reduced to an additional budget of £100 million over 4 years given that there will be fewer services transferred.

16.1 Baseline

The anticipated overspend for MSFT in 2013/4 is £20.2 m and is taken as the baseline. (In fact it is currently predicted to be £18-19m but I will assume £20.2m in accordance with the TSA figures).

16.2 Additional Costs

The TSA anticipates additional annual costs for the services currently provided by MSFT at £29.1 m pa.

a) £10.5 million of this relates to the cost of additional capital expenditure which is assumed to be approximately £200m at 5%.

If the additional capital expenditure required (which is already considered by some NHS professionals I have consulted to be very high) is reduced by half, that would in

return reduce this cost to c £5.5 m.

b) Inflation and the impact of reduced revenues are estimated to cost £17.4 m per annum. Given that, under my revised proposals, revenues would not fall as much for the Stafford and Cannock sites as more current activity would be retained, it is reasonable to assume that this inflation/revenue impact would be perhaps £4m less at £13.4 m.

It should also be noted that these inflation and tariff pressures will apply to all acute trusts and in particular the smaller ones.

This is a point which I have raised frequently in and out of Parliament and needs to be addressed by Monitor who take on responsibility for tariffs from 1 April 2014 and the Government.

c) The additional ambulance costs are forecast at £1.2 m. With my revised proposals, many of the forecast ambulance transfers should not be necessary. However, my assumption is that the TSA's additional cost for ambulances is too low given the increased number of transfers under their proposals. Hence I do not propose any change to this figure.

Hence my estimate for total additional costs is £20.1 m instead of £29.1 m.

16.3 Additional savings

The TSA estimates total annual savings of £40.8 m.

a) £11.6 m per annum can be saved through reducing executive management and back office functions and during current level of overheads to the NHS average.

This reduction over 4-5 years appears reasonable. However it is also reasonable to assume that a portion of the reduction in shared overhead costs should be allocated to the trusts taking over MSFT. This is a point which has been made to me by the Chief Executive and Chairman of UHNS.

My assumption is that about £6m per annum is attributable to shared overheads and hence £3m should be removed from the annual savings attributable to MSFT.

However if the balance of £5.6m is assumed to represent the annual savings from reducing MSFTs' costs to the NHS average when they are estimated to be 18% higher, that seems too low given a cost base of £170m pa. At that level, MSFT's costs could be reduced by some £30m without affecting services. This does not seem to me to be reasonable. However an increase in the savings per annum from £5.6m to £9m over 4-5 years in bringing MSFT's costs down TOWARDS the NHS

average would appear possible.

b) £8.6m can be saved from a combination of reduction in various clinical and ward costs which would not longer be required under the TSA's draft recommendations.

Given that my proposal is to retain most of these services, the large majority of these savings will not be achieved. However some support services (which can be effectively combined on one site) will be moved so it is assumed that £7.0m of the £8.6m of savings will not be achieved and hence just £1.6m achieved.

c) £6.2m can be saved from staff and non-staff services due to closer networking. I am assuming that this will continue to be possible as I support the merger of the Stafford and Cannock Hospitals with other larger trusts.

d) £4.0m can be saved by reducing surplus space at Stafford and Cannock. I am assuming that this will continue to be possible as most of this relates to Cannock where my proposals are the same as those of the TSA.

e) £10.4m can be saved through general cost improvements such as more bulk purchasing. This is in line with savings expected by all trusts. This figure seems ambitious to me but it is not affected by the difference between my proposal and that of the TSA.

Hence my estimate of total savings per annum by 2017/18 is £34.2m.

Taking these changes together, the result is

£ millions

Current baseline. (£20.2)
Additional costs. (£20.1)
Additional savings. £34.2

Net 2017/18. (£6.1)

Therefore the ongoing loss under my proposal is estimated to be no more than that under the TSA 's current proposal and possibly a little less.

The reason is that the reduction in the annual cost of the additional capital expenditure together with a lower decrease in revenues and a faster move towards NHS average costs would more than offset the additional costs incurred by maintaining services which the TSA proposes to move away from Stafford.

This still leaves an annual deficit which, as with the TSA's proposals, needs to be dealt with by the end of the 4-5 year transition period.

17.0 National policy impact on NHS finances between now and the end of the transition period

There are several changes in NHS financing which may occur between now and the end of the transition period of 4-5 years.

a) The review of per caput funding for CCGs should result in a fairer allocation of funds to CCGs in South Staffordshire. Currently, the South Staffordshire CCGs have a funding shortfall of c£40m per annum under the 'fair shares' calculations. Of this, £20m is attributable to the Stafford & Surrounds and Cannock Chase CCGs.
b) Tariffs, which is currently squeezing acute and emergency services, will be under review as responsibility for it passes to Monitor in 2014. It is quite possible that the tariff system, under which the TSA proposals are made, will change substantially.
c) The necessary changes to integrate acute and community services as well as health and social care are very likely to see more pooling of funding which is currently segregated.
d) The impact of a continued rise in the population as well as increased life expectancy may see public and hence political attitudes change towards health and social care funding.

For all these reasons, it is prudent and reasonable, while taking the important decision to dissolve MSFT, not to make substantial changes on financial grounds to good and safe clinical services, which are greatly valued by patients, when they may be financed on a very different basis by 2017-2018..

APPENDIX 1

Questions of National Importance arising from this Administration

The Administration (and I include in that the period covered by the work of the Contingency Planning Team (CPT)) has been an extremely difficult time both for the people served by MSFT and its staff. It has also raised questions of national importance which should have been addressed by Government and the medical professions a long time ago. They must now be properly confronted.

The first question is whether, as a country, we really wish to close general non-specialist services at smaller District General Hospitals (DGH) and centralise them in large specialist hospitals which are a considerable distance from patients' homes.

It is assumed by those running the NHS that this is inevitable and the right thing to do. However they have neither convinced all clinicians and certainly not large numbers of patients. They point to the success of the model of centralising acute stroke and cardiac care as well as major trauma. However general paediatric and maternity services do not fall in the same category. The Prime Minister himself warned in 2010 against consolidating maternity services into larger and larger units.

The second question is over the minimum specification for an Accident and Emergency (A&E) Department in a DGH. Professor Sir Bruce Keogh is doing some important work on this at present. A&E Departments admit unselected patients and they must therefore conform to a minimum specification with a core of functions on site as they are dependent on other services. It is not safe to 'salami slice' them below that core. This is particularly important in the case of MSFT where it proposed that there will no longer be consultants in paediatrics, obstetrics and gynaecology and critical care on site.

The third question relates to the impact of tariff reductions on emergency and acute care. As the Administrators point out (105):

"The Department of Health has used the tariff system to try and influence changes to working practices in order to reduce the number of emergency admissions."

However they then go on to limit their comments to the 'Payment by Results' guidance which reduces and removes payments for emergency admissions or readmissions under certain circumstances.

This is not the full story. Tariffs for emergency and acute activity have been reduced constantly since 2009. The reason is to transfer NHS money from the acute sector to primary and community care. Given the ageing population and the pressure on NHS funding, this is understandable. However, while 3-4 years of this cost pressure have probably resulted in necessary efficiencies, we are reaching the stage where it is increasingly difficult to find those without serious impact on patient care. The letter from the A&E clinical leads in the West Midlands (Appendix J) is a sign of the pressure which is being experienced.

The further reduction of emergency and acute tariffs should be the subject of urgent national debate in Parliament and elsewhere and, in my opinion, should be suspended until the consequences have been clearly thought through. Otherwise dozens of administrations such as MSFT will follow at great expense to the taxpayer.

The Administrators do not believe that the tariff reductions for high levels of emergency admissions are the root cause of the financial problems at MSFT (106). However they do not consider whether the general reduction in emergency and acute tariffs is a problem. I will examine this question in detail below under 'Finances'.

Fourthly, there is the impact of the increasing specialisation of medicine in the UK. There are, according to the Royal College of Physicians and Child Health (RCPCH), 63 specialities in the UK compared with 30 in Norway. It is not apparent that the UK benefits from this when compared with Norway. However the impact of the NHS is very considerable.

i) as the RCPCH has pointed out, it risks leaving general medicine and surgery out in the cold. Yet these are skills – particularly in diagnosis - which are of vital importance to a National Health Service.
ii) it is inevitably more expensive as rotas have to be maintained for each speciality.
iii) it is likely to lead to a skills shortage in certain specialities. It is far more difficult to plan for a full complement of specialists throughout the NHS when there are 63 specialities than when there are 30.

It seems that the NHS has little or no say in or control over the number of specialities and yet it will be expected by the profession and the public to provide and fund them.

The final question is whether a Trust Special Administration (TSA) as currently constituted is the right way to bring about reconfiguration of services. I will address this in a separate paper to the Secretary of State for Health and Monitor. It is only right that the NHS and the Government should learn lessons from the difficult experience of a TSA at MSFT so that the problems it causes are not experienced by other communities in the UK.

The final and most important question is over who is determining the future shape of our NHS. Is it the medical professions who are responsible for providing quality care? Is it Government who funds it through our taxes? Or is it the people for whom the NHS exists, its patients who by definition are all of us?

For me, it should be all three. Yet so often the views of patients are ignored. That is why this consultation is so important. It will test whether arguments properly made by users of the services of MSFT are given the weight they should be.

APPENDIX 2

Critical Care – further details from Head of CCU

Acutely ill patients.

Track and Trigger systems are now a fundamental part of managing the acutely ill patient. These are well embedded at Stafford and are a standard across all acute trusts. Outreach services from Critical Care are a basic response to the deterioration in a patient on the ward. The Critical Care medical staff provide the support and first line of outreach. It is very important to have early recognition of deteriorating patients so that appropriate measures are put in place to turn around the course of the illness or escalate the treatment levels promptly. This service currently manages 200-300 patients per month. To remove it would pose a considerable risk to the safety of patients at Stafford. The presence of Critical Care to Level 3 intensive care provides the full patient pathway to safely manage the patient.

Acute Critical Care period

The Acute Critical Care period is vital to the outcome of the patient. Expertise in Critical Care management of all organ systems failures is required and not just intubation and ventilation.

The acutely ill patient with sepsis is a classic common example. Guidelines drive care to be given quickly with experts administering an guiding the therapy. These patients are inherently unstable and many could not be transferred in an ambulance. This stabilisation requires a critical care facility where everything is organised. Sometimes these patients require days of therapy before they could be considered stable enough for transfer.

A facility and staff to manage these patients with the relevant equipment is therefore essential. If that facility is in place, then transfer becomes unnecessary unless clinically indicated.

Transfer of patients

Where there is a benefit to the Level 3 patient, then transfer must be considered. This is well recognised for:

a) Paediatric patients – where expertise is centralised at major centres such as UHNS or Birmingham;
b) Neurosurgery.

Transfer is risky and requires expert personnel trained in the transfer of the critically ill. Where expertise and capacity is available locally, there is no benefit, only risk, in a transfer to another unit.

An example of this is pneumonia, the commonest medical condition presenting to critical care. These cases are admitted through A&E and are treated by acute physicians but sometimes deteriorate to require Critical Care for advanced oxygen

therapy and sometimes ventilation. They often require 3 weeks of Critical Care stepping down to Level 2 at some point and then back to ward level care when appropriate. Stafford can safely manage these cases with local respiratory speciality help and have done for many years.

Another example is acute peritonitis. Even though Stafford can manage all the Critical Care elements of the treatment, if there are no surgeons or facility on site, the patient after stabilisation may need a transfer to receive the surgery at the right time.

Transferring patients introduces other risks. If key staff are taken out for a transfer they can be absent from their role sometimes for many hours putting other services and patients at risk.

Another consequence of the removal of Level 3 Critical Care would be the transfer of potentially ill patients. Clinically and ethically, the tendency would be towards transfer before patients became unstable, not afterwards. This would place a large increase in demand on beds at UHNS and result in a decrease in acute medical cases at Stafford putting the viability of the overall model at risk. In addition, the stabilisation of Level 2 patients for transfer would have to make them Level 3 as part of the safe transfer protocol. This would increase the number of level 3 patients at the receiving hospital, putting greater pressure on level 3 beds there, and would be to the detriment of the patient.

Absence of Level 3 care in Stafford would also limit the evaluation of patients referred to critical care. Currently the CCU sees many patients at the request of other consultants to assess their suitability and for very many it is not the right therapeutic pathway. Under the TSA model, that selection would not be available and so many patients would have to be placed in Critical Care and transferred without any assessment of survival. That assessment cannot be done adequately over the telephone.

The number of beds required under the TSA model for Level 2 (HDU) is therefore inadequate as it does not take these factors into account.

APPENDIX 3

Alternative proposal for CCU

The Stafford CCU team has consulted widely and visited a trust in Kent where a merger occurred some years ago. The Canterbury consultants and Medical Director were clear that having an A&E department and an acute medical team requires a complete Critical Care service and unit.

The proposal for Stafford is therefore a CCU with 5 nurses on duty allowing flexibility of Levl 2 and Level 3 care. This is modelled from medical patient flow over the past 18 months.

This represents a reduction or transfer of at least 2 nurses and 3 beds from the current Stafford establishment. Stafford would therefore have 4 HDU beds (as currently proposed by the TSA) and 3 Level 3 beds.

The Critical Care Division (merged with UHNS) would manage both sites and nurses would rotate where applicable to maintain skills and portfolio. Critical Care consultants would rotate to UHNS to maintain their skills and portfolio.

On call cover would be maintained at Stafford with the local Critical Care and Anaesthetic consultants and, where applicable, advice from the UHNS Critical Care consultant.

Critical Care cover at UHNS could then be supplemented by the current Stafford Critical Care consultants.

Middle Grade cover would continue at Stafford as would training opportunities.

As a result of this compared with the TSA proposals):

- Medical patients who can be safely managed would be kept at Stafford;
- Acutely ill patients could b e managed safely without increased risk;
- Medically difficult postoperative elective surgical cases could be managed;
- Other speciality needs as listed in 9.3 above could be managed;
- Medical and surgical patients with lengthy stays in the CCU on the major acute site could be repatriated to Stafford (this is currently done but the numbers could increase);
- More capacity across more sites would be retained in the North West Midlands Critical Care network;
- There would more support for A&E and Paediatrics.
- The risk and problems of transfer would be minimised;
- Services would be maintained for patients at Stafford;
- Retention of CCU staff would improve;
- Utilisation of the UHNS CCU would also improve.

The financial consequences would be:

- Less duplication of resource on the two sites. Under the current proposal, for each Level 3 patient at Stafford, a place has to be available both at Stafford and UHNS for the transfer to occur.
- Increased utilisation of staff at Stafford and fewer additional staff required at UHNS;
- Less duplication of equipment. Each bed space requires equipment of £60-70,000 together with servicing costs.
- Fewer ambulance transfer costs. Each patient retained saves 2 journeys.
- Reduction in the cost of visitors' travel costs and time. Each 3 week stay in hospital in UHNS would equate to £250 (bus) or (£1200) taxi for visitors.

- Reduced transfer of Level 2 or Level 1 patients at risk of deterioration;
- Better use and occupancy of the medical unit in Stafford.

APPENDIX 4

Travel

Increased travel time for patients and visitors is a serious consequence of the proposals. The CPT report used data which is not recognised by me or many constituents who have written to me.

For most people currently using the services at Stafford and who will need under these proposals to travel to UHNS or RWH, travel time will increase, in some cases by 30-45 minutes if travelling by private transport - more if the main arterial roads A34, A449 or M6 are slow-moving. There is also a problem with car parking at both UHNS and RWH which would need to be addressed.

This is of particular concern to the following groups:

a) women going into labour;
b) children and their parents needing emergency care between 10pm and 8am when the proposal is that there is no access to Stafford;
c) those without cars who rely on public transport and who are likely to be on a lower income;
d) residents of the more remote rural areas served by Stafford.

I will make a more detailed submission on this subject to the Health Inequalities Assessment group.

Given that under the proposals of the Administrator, UHNS and Stafford are likely to merge, a free regular bus service between the two sites should be offered as in Calderdale and Huddersfield (358).

APPENDIX 5

Patient Choice

These proposals significantly reduce the choice for:

a) pregnant women in the area served by Cannock and Stafford hospitals as to where to have their children;
b) sick children who will now be treated to a considerably greater extent at hospitals which are further away from home and thus less accessible for frequent visits.

APPENDIX 6

Impact on other hospitals in the region

The decision to retain an A&E 14/7 will certainly reduce the pressure on other A&E's which, as pointed out in my response to the CPT report, would probably be unable to cope with the increase in demand. The recognition by the TSA of this is welcome.

Nevertheless, the TSA proposals will require other hospitals in the region to receive from Stafford at the least:

a) all births currently taking place;
b) much of the paediatric work, including all in-patient paediatrics;
c) serious emergency surgery;
d) serious medical cases which need to be transferred to a level three CCU.

All these services are as the report states under pressure in UHNS and RWH. The proposal is therefore to expand the facilities and presumably staffing at UHNS and RWH to serve the patients currently treated at Stafford.

I argue in the case of a), b) and d) that these transfers are unnecessary on clinical grounds and that, since Stafford has the capacity to treat them, they should remain at Stafford thus saving the expense of providing the additional capacity at UHNS and RWH.

Clearly there are also financial considerations and I will address these in my second submission.

APPENDIX 7

Population

The TSA's report addresses the question of the population served by Stafford and Cannock in more detail than the CPT report.

There are many differing measures of the population served and they range between approximately 200,000 and 300,000. However it is clear that that this population is both increasing and ageing.

While the population served is therefore currently below or on the lower margin of that specified for an acute (non-specialised) hospital with a range of general services, it is of a size where it makes sense (assuming a merger with UHNS) to do everything possible to retain standard services locally rather than moving them.

The TSAs argue (93ff) that a full-scale acute general hospital is not appropriate at Stafford. I do not argue for that, rather for an acute general hospital networked within a larger acute trust .

APPENDIX 8

Integration of health and social care

Health policy under successive Governments has emphasised the integration of health and social care. The introduction of the frail elderly unit within the MAU is a welcome step in this but the Administration is an opportunity to do far more. I propose that Stafford and Cannock Hospitals become hubs for integrated health and social care in close cooperation with the Staffordshire and Stoke-on-Trent Community Trust and the CCGs.

APPENDIX 9

General

Attendances (Para 92)

The fall in attendances in 2012-13 is noted. However the reason for much of the fall (my estimate is 4,000-5,000) is the night-time closure of A&E. Like is therefore not being compared with like.

The main impact of the serious problems which Stafford had was felt in 2008-2010 at the time of the HCC investigation and the publication of its findings. Since then, there has been very considerable improvements at Stafford and attendances are stabilising.

Cessation of services (Para 101)

The cessation of cardiac/major stoke/trauma was not in the past three years but earlier and was the result of national policy rather than local problems.

Rationale for not providing networked solutions for paediatrics and maternity

Dr Paul Watson, Regional Director (Midlands and East) writes for NHS England:

“The TSA proposal envisages the removal of emergency surgery, in-patient paediatrics and obstetrics from the Stafford site. Whilst we can see the clinical arguments for doing this, we would encourage you to ensure that the consultation document sets out very clearly why the networked assumption being proposed for A&E and general medicine cannot be applied to these services. Likewise, it would also be helpful if the rationale for excluding a midwife-led delivery unit is clearly set out.”

I do not see in the consultation document where the clinical arguments for not providing a networked assumption for emergency surgery, in-patient paediatrics and obstetrics is clearly set out. In addition, the rationale for excluding a midwife-led delivery unit is brief and unconvincing.